Waco Center for Youth
Waco, TX

PHYSICIAN DISCHARGE ORDER Inquiry

Client Name: EJEM,JUSTIN
Assigned ID: 000238798
Date Of Birth: 03/01/1992
Episode Number: 2

Episode Start Date: 09/10/2007
Episode End Date: 04/17/2008
Data Entry By (Login): ANCHA LAKSHMI
Data Entry Date: 04/17/2008

GENERAL INFORMATION

Assessment Date: 04/17/2008

Assessment Time: 10:23 AM

Draft/Final: Final

Assessing Clinician: ANCHA,LAKSHMI (000496)

NOTE

Reason for Admission: Danger of Deterioration

Client To Be: Discharged

Anticipated Discharge Date: 04/17/2008

Discharge Diagnosis:
I: Bipolar Disorder NOS; ADHD-Combined Type; Parent-Child Relational Problem,Suspected physical abuse.
II: No diagnosis
III: None
IV: Problems with primary support,educational and psychosocial problems
V: GAF-48

Discharge Medications - Name, Dosage, and Reason for Use:
PSYCHOTROPICS:
1)Depakote 500 mg by mouth every morning and 500 mg at bedtime
2)Concerta 72 mg by mouth every morning.
3)Seroquel 150 mgs. by mouth every morning and at noon and 200 mgs. at bedtime
4)Benadryl 75 mgs. by mouth at bedtime

Condition at Discharge: Partial Remission

Child/Adolescent Patient Discharged To:
PT IS DISCHARGED TO HIS LAR RICK EJEM on 04/17/08.

Allergies: Yes

Allergy Comments:
NASAL PAN MIST

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PHYSICIAN P. NOTE

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Episode Start Date: 09/10/2007
Episode End Date: 04/17/2008
Data Entry By (Login): ANCHA LAKSHMI
Data Entry Date: 02/29/2008

1)Continue Depakote 500 mgs. by mouth every morning and 500 mg by mouth at bedtime for mood stabilization.
2)Continue Concerta 36 mg two tablets by mouth every morning
3)Continue Seroquel 50 mgs. by mouth every morning and noon and increased to 150 mgs. at bedtime for mood stabilization.
4)Continue Benadryl to 75 mgs. by mouth at bedtime
NON-PSYCHOTROPICS:
1)Continue Neutrogena soap twice a day for mild facial acne.
2)Continue Stridex Pad at bedtime.
3)Continue patient on high calorie diet and also provide him with a high calorie supplement during snack time.
4)Monitor patient's eating habits and weight.

NOTE
Please Check all Note Types that apply before continuing!

Note:
Patient attended treatment team on 02-20-08.

Patient continues to have an intense conflict with his roommate. He indicated that his roommate wanted him to perform oral sex. Patient decided to sleep in the timeout room as a result. Patient was also given an emergency dose of Thorazine 50 mgs. on 02-13-08 and 02-14-08 for extreme agitation. He continues to be easily influenced by peers' negativity. According to the TTC CPS closed the investigation of suspected physical abuse against the patient's family. CPS will continue to monitor the patient's family. In addition, it was indicated that the patient's stepmother would like the patient to exhibit further improvement in behaviors before he can come home. Family therapy session has been scheduled for 02/23/08 to address the family issues.

Patient was appropriately dressed and groomed. His mood was pleasant. Affect was congruent. His activity level was appropriate for age. He maintained fairly good attention and concentration during the treatment team. No evidence of psychotic symptoms. No tics or AIMS. No suicidal and/or homicidal ideations.

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NURSING OBSERVATION NOTE (BRIEF) Inquiry

Client Name: EJEM,JUSTIN
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Date Of Birth: 03/01/1992
Episode Number: 2

Episode Start Date: 09/10/2007
Episode End Date: 04/17/2008
Data Entry By (Login): WILLIAMS TES
Data Entry Date: 04/13/2008

DATE/TIME/SHIFT

Assessment Date: 04/13/2008

Assessment Time: 08:30 PM

Draft/Final: Final

Shift: Evening

NURSING OBSERVATION/ASSESSMENT

Affect/Mood: Sullen

Nursing Observation/Assessment Comments:
PATIENT ASKED TO TALK WITH THE RN REGARDING AN INCIDENT THAT HAPPENED TO HIM THE OTHER NIGHT. THE PATIENT STATED THAT HE WAS SEXUALLY ASSAULTED BY HIS ROOMMATE. THIS RN HAD CAMPUS RN COME OVER AND VERIFY WHAT THE PATIENT HAD STATED AND TAKE ACTIONS APPROPRIATELY. AFTER CAMPUS RN LISTENED AND QUESTIONED PATIENT, HE DENIED THAT INCIDENT HAPPENED. HE DID HOWEVER STATE THAT HE WANTED TO HAVE A ROOM CHANGE AS HE IS AFRAID THAT THIS WOULD HAPPEN. OTHER STAFF BROUGHT IN TO TALK WITH THE PATIENT REGARDING WHAT HAPPENED AND IT WAS FELT THAT EXTRA BED ROOM CHECKS SHOULD BE DONE FOR THE SAFETY OF ALL PATIENTS ON THIS UNIT. THERAPIST AND NURSE MANAGER WERE LEFT MESSAGES BY THIS RN AS TO WHAT HAS BEEN REPORTED, AND THAT A UNIT MEETING SHOULD BE HELD. PATIENT WILL NOT SLEEP IN HIS ROOM TONIGHT AND CHANGES WILL BE MADE ACCORDINGLY. THE PATIENT STATES HE FEELS COMFORTABLE WITH SUCH ACTIONS AND WILL ALSO TALK WITH THERAPIST AND RN IN THE MORNING. PATIENT PRESENTLY IN ROOM BY HIMSELF AND ASLEEP.

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PATIENT DAILY FUNCTIONING CHECKLIST Inqu

Client Name: EJEM,JUSTIN
Assigned ID: 000238798
Date Of Birth: 03/01/1992
Episode Number: 2

Episode Start Date: 09/10/2007
Episode End Date: 04/17/2008
Data Entry By (Login): HARRISON GLORIA
Data Entry Date: 02/13/2008

GENERAL INFORMATION

Assessment Date: 02/13/2008

Assessment Time: 02:20 PM

Draft/Final: Final

Assessing Clinician: HARRISON,GLORIA (000387)

Primary Language: English

Is the preferred language English: Yes

DAILY LIVING ACTIVITIES

ADLs: Independent

Ambulating: Self

Bathing: Shower

Grooming Hygiene: Clean

DIET--APPETITE

Percent of Breakfast Eaten: 50%~INACTIVE

Percent of Lunch Eaten: 50%~INACTIVE

BEHAVIOR AND ACTIVITY

Attendance of Activities: Attends Activities with no prompts

Response to Requests: Behavior Requires Staff Intervention

Behavior and Activities Comments:
CLIENT GOT INTO AN ARGUMENT WITH ONE OF HIS PEERS. HE AND HIS PEER USED PROFANITY FREELY, THREATENED HIS PEER,STATED" I WILL KNOCK THE FUCK OUT OF YOU IF YOU DON'T LEAVE ME THE FUCK ALONE" HE FLIPPED HIS PEER OFF SAYING "FUCK YOU". HE REFUSES TO FOLLOW STAFF INSTRUCTIONS. HE WOULD NOT MIND HIS OWN BUSINESS AND GIVE PEER HIS BODY SPACE. STAFF ASKED HIM TO KEEP QUIET AND EAT HIS BREAKFAST HE STATED TO STAFF"SHUT UP"

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PATIENT DAILY FUNCTIONING CHECKLIST Inqu

Client Name: EJEM,JUSTIN
Assigned ID: 000238798
Date Of Birth: 03/01/1992
Episode Number: 2

Episode Start Date: 09/10/2007
Episode End Date: 04/17/2008
Data Entry By (Login): FOY ROBERT
Data Entry Date: 02/13/2008

GENERAL INFORMATION

Assessment Date: 02/13/2008

Assessment Time: 08:44 PM

Draft/Final: Final

Assessing Clinician: FOY,ROBERT (000154)

Primary Language: English

Is the preferred language English: Yes

DAILY LIVING ACTIVITIES

ADLs: Independent

Ambulating: Self

Grooming Hygiene: Unkempt

DIET--APPETITE

Percent of Dinner Eaten: 50%~INACTIVE

Percent of Snack Eaten: 100%~INACTIVE

LEVEL OF OBSERVATION/MONITORING

Precaution Type: Routine Monitoring

Level of Monitoring: Routine

Level Implemented: Routine

BEHAVIOR AND ACTIVITY

Attendance of Activities: Refuses Activities

Socialization: Socializes with Others Independently

Response to Requests: Behavior Requires Staff Intervention

Behavior and Activities Comments:
PATIENT HAS BEEN VERY DISRUPTIVE. HE HAS BEEN NON-COMPLIANT WITH STAFF REQUEST. HE HAS BEEN INVOLVED IN A PHYSICAL ALTERCATION WITH A PEER AND A "STAND-OFF " WITH THE SAME PEER AS OF THIS ENTRY. HE REFUSED TO TAKE HIS

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PATIENT DAILY FUNCTIONING CHECKLIST Inqu

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Episode Start Date: 09/10/2007
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Data Entry By (Login): FOY ROBERT
Data Entry Date: 02/13/2008

SHOWER ALSO. HE WAS ASSESSED A (0) ON THE 3-11 SHIFT.

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PATIENT DAILY FUNCTIONING CHECKLIST Inqu

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Date Of Birth: 03/01/1992
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Episode Start Date: 09/10/2007
Episode End Date: 04/17/2008
Data Entry By (Login): FOY ROBERT
Data Entry Date: 02/13/2008

GENERAL INFORMATION

Assessment Date: 02/13/2008

Assessment Time: 09:05 PM

Draft/Final: Final

Assessing Clinician: FOY,ROBERT (000154)

Primary Language: English

Is the preferred language English: Yes

BEHAVIOR AND ACTIVITY

Behavior and Activities Comments:
PATIENT HAS CONTINUED TO ESCALATE TO THE POINT HE IS CONTINUING TO THREATEN HIS PEER AND BROKEN HIS OWN GLASSES.HIS GLASSES HAVE BEEN PLACED IN AN ENVELOPE AND PLACED IN THE STAFF OFFICE.

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PATIENT DAILY FUNCTIONING CHECKLIST Inqu

Client Name: EJEM,JUSTIN
Assigned ID: 000238798
Date Of Birth: 03/01/1992
Episode Number: 2

Episode Start Date: 09/10/2007
Episode End Date: 04/17/2008
Data Entry By (Login): AAGESEN MICHAEL
Data Entry Date: 02/17/2008

GENERAL INFORMATION

Assessment Date: 02/17/2008

Assessment Time: 05:08 AM

Draft/Final: Final

Assessing Clinician: AAGESEN,MICHAEL (000476)

Primary Language: English

Is the preferred language English: Yes

SLEEP PATTERNS (11-7 Shift Only)

Sleep Patterns Comments:
AT THE BEGINNING OF THE SHIFT PT. WAS ASLEEP IN THE TIME OUT ROOM SO THAT HE WOULD NOT HAVE ANY PROBLEMS WITH HIS ROOMMATES. NO PROBLEMS NOTED AT THIS TIME, PT. WILL CONTINUE TO BE MONITORED FOR THE DURATION OF THE SHIFT.

Number Hours Slept: Slept all Night

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PATIENT DAILY FUNCTIONING CHECKLIST Inqu

Client Name: EJEM,JUSTIN
Assigned ID: 000238798
Date Of Birth: 03/01/1992
Episode Number: 2

Episode Start Date: 09/10/2007
Episode End Date: 04/17/2008
Data Entry By (Login): AAGESEN MICHAEL
Data Entry Date: 02/18/2008

GENERAL INFORMATION

Assessment Date: 02/18/2008

Assessment Time: 05:54 AM

Draft/Final: Final

Assessing Clinician: AAGESEN,MICHAEL (000476)

Primary Language: English

Is the preferred language English: Yes

SLEEP PATTERNS (11-7 Shift Only)

Sleep Patterns Comments:
AT THE BEGINNING OF THE SHIFT PT. WAS ASLEEP IN THE TIMEOUT ROOM BECUASE HE WAS HAVING PROBLEMS WITH HIS ROOMMATES DURING RELAXATION TIME. NO PROBLEMS NOTED AT THIS TIME, PT. WILL CONTINUE TO BE MONITORED FOR THE DURATION OF THE SHIFT.

Number Hours Slept: Slept all Night

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PATIENT DAILY FUNCTIONING CHECKLIST Inqu

Client Name: EJEM,JUSTIN
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Date Of Birth: 03/01/1992
Episode Number: 2

Episode Start Date: 09/10/2007
Episode End Date: 04/17/2008
Data Entry By (Login): AAGESEN MICHAEL
Data Entry Date: 02/22/2008

GENERAL INFORMATION

Assessment Date: 02/22/2008

Assessment Time: 06:16 AM

Draft/Final: Final

Assessing Clinician: AAGESEN,MICHAEL (000476)

Primary Language: English

Is the preferred language English: Yes

SLEEP PATTERNS (11-7 Shift Only)

Sleep Patterns Comments:
PT. WAS ASLEEP AND IN BED AT THE BEGINNING OF THE SHIFT. PT. SLEPT IN THE TIMEOUT ROOM PER HIS REQUEST. NO PROBLEMS NOTED AT THIS TIME, PT. WILL CONTINUE TO BE MONITORED FOR THE DURATION OF THE SHIFT.

Number Hours Slept: Slept all Night

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PATIENT DAILY FUNCTIONING CHECKLIST Inqu

Client Name: EJEM,JUSTIN
Assigned ID: 000238798
Date Of Birth: 03/01/1992
Episode Number: 2

Episode Start Date: 09/10/2007
Episode End Date: 04/17/2008
Data Entry By (Login): AAGESEN MICHAEL
Data Entry Date: 03/11/2008

GENERAL INFORMATION

Assessment Date: 03/11/2008

Assessment Time: 06:22 AM

Draft/Final: Final

Assessing Clinician: AAGESEN,MICHAEL (000476)

Primary Language: English

Is the preferred language English: Yes

SLEEP PATTERNS (11-7 Shift Only)

Sleep Patterns Comments:
PT. WAS IN BED AND ASLEEP AT THE BEGINNING OF THE SHIFT. PT. SLEPT IN THE ACTIVITY ROOM BECAUSE HE WAS HAVING SOME PROBLEMS WITH HIS ROOMMATE AT BEDTIME BEFORE THE BEGINNING OF THE SHIFT. NO NOTED PROBLEMS AT THIS TIME, PT. WILL CONTINUE TO BE MONITORED FOR THE DURATION OF THE SHIFT.

Number Hours Slept: Slept all Night